

* Social security number required pursuant to IC 4-1-8-1

INDIANA STATE BOARD OF HEALTH FACILITY ADMINISTRATORS PROFESSIONAL LICENSING AGENCY

402 West Washington Street, Room W072 Indianapolis, Indiana 46204 Telephone: (317) 234-2051 E-mail: pla6@pla.IN.gov

THIS FORM IS FOR ENDORSEMENT CANDIDATES ONLY.

	APPLICANT INFORMATION	N		
Name (last, first, middle, maiden)	Social Security number *			
Address (number and street, city, state, and ZIP code)				
License number	Date of issuance (month, day, year)		Date of birth (month, day,	year)
I hereby authorize	to furn	nish the Professional L	icensing Agency with the	e information below.
Signature of applicant			Date (month, day, year)	
THIS SECTION IS	TO BE COMPLETED AND AUTHOR!	ZED BY THE STATE	ROARD	
	bove completed an administrator-in-tra			
Name of facility where training took place	Length of training p		rogram	
			months	hours
Address (number and street, city, state, and ZIP code)				
Preceptor / Supervisor of training program				
Type of facility				
Form completed by (printed name)			Please affix Board seal	
Title			i icase allix boald seal	
Signature	Date (month, day, year)			